STATE OF MICHIGAN

DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS

OFFICE OF FINANCIAL AND INSURANCE REGULATION

Before the Commissioner of Financial and Insurance Regulation

In the matter of

XXXXX
Petitioner

v **File No. 121427-001-SF**

Blue Cross Blue Shield of Michigan
Respondent

Issued and entered
this 28th day of September 2011
by R. Kevin Clinton
Commissioner

ORDER

I. PROCEDURAL BACKGROUND

On May 17, 2011, XXXXX (Petitioner), filed a request for external review with the Commissioner of Financial and Insurance Regulation under Public Act No. 495 of 2006, MCL 550.1951 *et seq.* The Commissioner reviewed the material submitted and accepted the request on May 24, 2011.

The Petitioner receives health care benefits through XXXXX University, a self-funded plan administered by Blue Cross Blue Shield of Michigan (BCBSM). Under Section 2(2) of Act 495 of 2006, MCL 550.1952(2), the Commissioner conducts this external review as though the Petitioner was a covered person under the Patient's Right to Independent Review Act (PRIRA), MCL 550.1901 *et seq*.

To address the medical issues in the case, the Commissioner assigned the case to an independent medical review organization which provided its analysis and recommendation to the Commissioner on June 9, 2011. (A copy of the complete report is provided to the parties with this Order.)

II. FACTUAL BACKGROUND

The terms of the Petitioner's coverage are contained in BCBSM's *Community Blue Group Benefit Certificate* (the certificate).

From February 7 through February 18, 2011, the Petitioner received care at XXXXX Center in XXXXX, XXXXX, an inpatient rehabilitation facility. BCBSM denied coverage arguing that the care could have been provided by an approved home health care program. The Petitioner appealed the denial through BCBSM's internal grievance process. BCBSM did not change its decision and issued its final adverse determination on April 14, 2011.

III. ISSUE

Did BCBSM properly deny coverage for the Petitioner's care at XXXXX from February 7 through 18, 2011?

IV. ANALYSIS

BCBSM's Argument

In its final adverse determination of April 14, 2011, BCBSM advised Petitioner:

> I realize that you disagree with our determination, and that you feel that skilled care was provided during the days in question. However, physical therapy alone does not support "skilled care." I am also empathetic to your living arrangements. However, these circumstances do not warrant inpatient benefits, and benefit decisions must be made within the provisions of coverage.
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> Please not that your admission on February 4 to the same facility was approved correctly. We were informed at that time that you were being discharged from an acute care hospital after being treated for an acute condition and that you had a low functioning level supporting the need for skill care. Subsequently, following your second release on February 7, the documentation shows that you were functioning at a higher level and that the need for skilled care was no longer supported.

Petitioner's Argument

The Petitioner states that on February 1, 2011, she had her right knee surgically replaced. On February 4, 2001, she was sent to XXXXX for inpatient rehabilitation and BCBSM pre-approved this admission. On February 4, 2011, she had atrial fibrillation and the next morning she returned to the hospital. By February 6, 2011, the Petitioner's heart was stabilized and she returned to XXXXX on February 7.

While at XXXXX, a registered nurse monitored her vital signs 24 hours a day and administered injections of Lovenox and other medications. She also received physical and occupational therapy.

BCBSM claimed that she was functioning at a higher level. The Petitioner believes she was not functioning at a higher level and now had the additional stress of atrial fibrillation. She provided a letter from her doctor indicating it was medically necessary for her to be at XXXXX.

Commissioner's Review

The question of whether the Petitioner's care at XXXXX was medically necessary was presented to an independent review organization (IRO) for analysis as required by section 11(6) of the Patient's Right to Independent Review Act. The IRO reviewer is a physician certified in physical medicine and rehabilitation who holds an academic appointment and has been in active practice for more than 15 years. The IRO report includes the following comments and conclusions:

> [I]n order for treatment at a skilled nursing facility level of care to be medically necessary, a patient must require skilled nursing and/or skilled rehabilitation services, the daily skilled services must be ones that as a practical matter, can only be provided on an inpatient basis in a skilled nursing facility and there must be an expectation for practical improvement with realistic goals. . . . [A]t the time of the member's transfer back to the skilled nursing facility on 2/7/11, she continued to have a medical need for skilled nursing oversight for her post operative anemia . . . incision care and monitoring and pain management. . . . [F]unctionally, the member required standby assistance with transfers and ambulation of 100 feet with a rolling walker and had fair standing balance. . . . [T]he member's right knee flexion was 65 degrees with an extension lag of 10 degrees and strength of 3/5. . . . [T]he member's range of motion was not at a functional level to allow her to return to her activities of daily living without major impairment. . . . [T]he member continued to need skilled inpatient rehabilitation to return to her maximal potential and had an expectation for practical improvement in a predictable time period.
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> [I]t was medically necessary for the member to have been treated at a skilled nursing facility level of care from 2/7/11 to 2/18/11.

While the Commissioner is not required in all instances to accept the IRO's recommendation, it is afforded deference. In a decision to uphold or reverse an adverse determination, the Commissioner must cite "the principle reason or reasons why the Commissioner did not follow the assigned independent review organization's recommendation." MCL 550.1911(16)(b). The IRO reviewer's analysis is based on extensive expertise and professional judgment and the Commissioner can discern no reason why that judgment should be rejected in the present case.

The Commissioner finds the Petitioner's skilled nursing care at XXXXX from February 7 through 18, 2011, was medically necessary and a covered benefit under the certificate.

V. ORDER

BCBSM's final adverse determination of April 14, 2011, is reversed. BCBSM is required to provide coverage for the Petitioner's care at XXXXX from February 7 through 18, 2011, within 60 days of the date of this Order and shall, within seven (7) days of providing coverage, submit to the Commissioner proof it has implemented this Order.

To enforce this Order, the Petitioner may report any complaint regarding implementation to the Office of Financial and Insurance Regulation, Health Plans Division, toll free (877) 999-6442.

Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than 60 days from the date of this Order in the circuit court for the county where the covered person resides or the circuit court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of Financial and Insurance Regulation, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.

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R. Kevin Clinton
Commissioner